

**RISK MANAGEMENT FUND  
MOTOR VEHICLE ACCIDENT REPORT**

STATE OF NORTH DAKOTA

SFN 51301 (Rev. 12-2001)

DEPARTMENT LOCATION CODE

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☐ Claim Form Requested  
☐ Destruction Hold Notice

**DRIVER RESPONSIBILITY:** Complete this original report immediately after the accident and fax a copy to 701-328-2514. Mail the original report to the ND Department of Transportation, State Fleet Services, 608 East Boulevard Ave., Bismarck, ND 58505-0700, no later than 2 days after the accident. If you have any questions, please call State Fleet Services at 701-328-1472 or 701-328-1434.

<b>AGENCY</b>	Agency Name	District/Division
	Address	Telephone Number

<b>TIME</b>	Date of Accident	Day of Week	Hour	A.M. <input type="checkbox"/>
				P.M. <input type="checkbox"/>

<b>LOCATION</b>	Highway Number	Posted Speed Limit	Location From Nearest City	Citation Issued <input type="checkbox"/> Yes
				<input type="checkbox"/> No
	City	Street	At Intersection With	

<b>TYPE</b>	<input type="checkbox"/> Backing	<input type="checkbox"/> Snowplowing/Sanding	<input type="checkbox"/> Right Angle	<input type="checkbox"/> Rear End
	<input type="checkbox"/> Turned Over	<input type="checkbox"/> Animal	<input type="checkbox"/> Head On	<input type="checkbox"/> You Hit <input type="checkbox"/> You Were Hit
	<input type="checkbox"/> Fixed Object	<input type="checkbox"/> Sideswipe	<input type="checkbox"/> Other(Describe) _____	

<b>STATE VEHICLE  No. 1</b>	<b>VEHICLE</b>	Year	Make	Model	Unit Number	
	Driver's Name			Driver's License Number		
	Telephone Number - Work			Telephone Number - Home		
	Home Address			City	State	Zip Code
	Damage (List Parts)				Estimate \$	
	Passengers		<input type="checkbox"/> Injured/Killed <input type="checkbox"/> Injured/Killed	Telephone Numbers Work Work		Telephone Numbers Home Home

<b>OTHER VEHICLE  No. 2</b>	<b>VEHICLE</b>	Year	Make	Model	License Plate	State
	Driver's Name			Driver's License Number		
	Telephone Number - Work			Telephone Number - Home		
	Home Address			City	State	Zip Code
	Damage (List Parts)				Estimate \$	
	Passengers		<input type="checkbox"/> Injured/Killed <input type="checkbox"/> Injured/Killed	Telephone Numbers Work Work		Telephone Numbers Home Home

<b>OWNER'S</b>	Insurance Company	Policy Number
	Address	Telephone Number

<b>DRIVER'S</b>	Insurance Company	Policy Number
	Address	Telephone Number

<b>WITNESS</b>	Name	Address	City	State	Zip Code
	Location To Accident	Telephone Number Work	Telephone Number Home		

<b>DAMAGE TO OTHER PROPERTY</b>	What	Estimate \$	Telephone Number Work	Telephone Number Home
	Owner/Name	Address		

<b>INJURED/ KILLED</b>	Name					Vehicle <input type="checkbox"/> 1 <input type="checkbox"/> 2	
	Address	City	State	Zip Code	Telephone Number Work	Telephone Number Home	
	Nature and Extent of Injury						

<b>CONDITIONS</b>	WEATHER <input type="checkbox"/> Clear <input type="checkbox"/> Raining <input type="checkbox"/> Snowing <input type="checkbox"/> Sleeting <input type="checkbox"/> Fog <input type="checkbox"/> Other _____
	ROADWAY <input type="checkbox"/> Dry <input type="checkbox"/> Icy <input type="checkbox"/> Slippery <input type="checkbox"/> Under Repair <input type="checkbox"/> Other _____
	Did Vehicle Have Any Defects? _____
	Were Seat Belts in Use? <input type="checkbox"/> Yes <input type="checkbox"/> No
	What Lights Were On? _____

Explain How Accident Occurred
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Diagram: Mark State Vehicle 1 And Other Vehicle 2
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State Employee	Department	Telephone Number
State Employee Completing Report	Telephone Number	Date